MEDICARE PRESCRIPTION DRUG COVERAGE WORKSHEET

1. What is your name as it appears on your Medicare card? ①

2. What is your Medicare Claim Number? ②

3. What is your date of birth?

Month/Date/Year

4. What is the effective date for your Medicare?

③Part A _____ ④Part B _____

Month/Date/Year *Month/Date/Year*

5. What is your Zip Code?_____ County? _____

Address, City, State _____

Phone # _____

*Questions 6 & 7 are optional. This information can help determine if you are eligible for Extra Help with Medicare Part D costs.

6. Check the **ONE** box that best describes your **INCOME**.*

Single, widowed, divorced or live apart from my spouse and:	Married and:
☐ My annual gross income is less than $17,820	☐ Our annual gross income is less than $24,030
☐ My annual gross income is greater than $17,820	☐ Our annual gross income is greater than $24,030

7. Check the **ONE** box that best describes your **LIQUID ASSETS**. Liquid assets are the total value of your savings, investments and real estate. Do not include your primary home, vehicles, burial plots or personal possessions.*

Single, widowed, divorced or live apart from my spouse and:	Married and:
☐ My assets are $13,640 or less	☐ Our assets are $27,250 or less
☐ My assets are greater than $13,640	☐ Our assets are greater than $27,250

8. List the pharmacy or pharmacies you use. (Required)

_____

Kansas SMP SHICK MIPPA

9. Which prescription drugs do you currently take? (Please also list the dosage, how often you take it per month and your monthly cost). **PLEASE PRINT CLEARLY. ATTACH AN EXTRA SHEET IF NEEDED.**

DRUG NAME	DOSAGE	30- DAY QUANTITY	MONTHLY COST

SHICK Disclaimer

SHICK Counselor Name:_____ Telephone: _____

I have reviewed a minimum of three Medicare Part D Prescription Drug Plans and have chosen the following plan: _____. I give the SHICK Counselor listed above my authorization to enroll me in the above plan using the information I have provided. I confirm that all information provided is truthful and accurate and I hereby release the SHICK Counselor, the SHICK organization and the State of Kansas from any liability whatsoever, known or unknown, related or pertaining my Medicare Part D enrollment herein. I also acknowledge that information discussed with the Counselor cannot be relied upon nor construed as legal advice. I understand that I may not change my drug plan until the next open enrollment period which will be October 15, 2017 to December 7, 2017.

I also understand the costs and covered medications quoted on the plan I've chosen may be subject to change.

Signature: _____ Printed Name: _____

Date: _____ Drug List ID: _____ Password Date: _____

Office Use Only: